HUDSON HEADWATERS
HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number	
Street Address	**City**	**State**	**Zip Code**

A) I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

B) To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) Information disclosed: *(please select one)*

☐ Medical information ☐ Dental information

- -

☐ Entire record set

☐ Date range: _____ to _____

☐ Other: _____

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select one)*

☐ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: _____

☐ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: _____

☐ Encrypted email: _____ ☐ Fax to: _____

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: _____ *Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:

I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date